

MEMORIAL HOSPITAL AT GULFPORT
CERTIFICATION BY CUSTODIAN OF MEDICAL RECORDS

STATE OF MISSISSIPPI

COUNTY OF HARRISON

The undersigned being duly sworn does state on oath as follows:

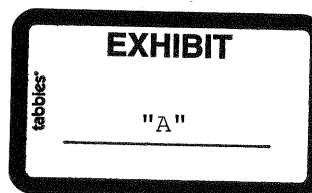
1. That she is the duly authorized custodian of the hospital medical records of MEMORIAL HOSPITAL AT GULFPORT and has the authority to certify records.
2. That the within and annexed are true and correct copies of requested portions from the medical records of MCBAY, GARY, DOB: 08/05/1976 as described in the correspondence received for these records.
3. The within and annexed records were prepared either by the personnel of the hospital or it's staff, physicians or by persons acting under the control either of them, in the ordinary course of hospital business at or near the time of the act, condition or event reported therein.


Signature of Custodian

SWORN AND SUBSCRIBED before me, this the 20 day of May 2009


Notary Public

MISSISSIPPI STATEWIDE NOTARY
MY COMMISSION EXPIRES SEPT. 8, 2010
BONDED THRU STEGALL NOTARY SERVICE



PHNS Inc - Hunter Account
Health Information Specialists

DUKES DUKES KEATING AND FANCA
2909 13TH ST
FL 6
GULFPORT, MS 39501-1925

Wednesday, May 20, 2009

Reference Number: MS36-2275973W

Facility: MEMORIAL HOSPITAL AT GULFPORT
4500 13TH ST
GULFPORT, MS 39501-2515
(228) 865-3044

Regarding Patient: GARY MCBAY

Dear Requestor:

Your request for medical records has been received by PHNS Inc - Hunter Account. PHNS Inc - Hunter Account has contracted with this medical facility to provide you with copies of the medical records you requested. Copies are made from the medical facility's original medical records. The confidentiality of these records is protected by federal and state law. These medical records are intended exclusively for the requested purpose and cannot be recopied or redistributed for other purposes without written informed consent of the patient.

Your request for medical records has been completed. There is a cost for providing these copies and an invoice is enclosed. Please see the attached invoice for payment details.

PLEASE REMIT CHECK TO:**PHNS Inc - Hunter Account**

PO BOX 671281,

Dallas, TX 75267-1281

Phone: 800-778-4839

Federal Tax ID Number: 72-1292247

BILL TO:

DUKES DUKES KEATING AND FANCA

2909 13TH ST

FL 6

GULFPORT, MS 39501-1925

Ship To:

Date: 5/20/2009 9:39:33 AM Invoice#: MS36-2275973W Amount Due: \$0.00		DUKES DUKES KEATING AND FANCA 2909 13TH ST FL 6 GULFPORT, MS 39501-1925							
Facility Name: MEMORIAL HOSPITAL AT GULFPORT Requested By: DUKES DUKES KEATING AND FANCA Patient Name: MCBAY, GARY Date of Birth: 8/5/1976 SSN: ***-**-4195		Insured Name: Reference#: Fee Approval: Pages Sent: 10							
Charge	Quantity	Rate	SubTotal	BaseFee	SearchFee	Tax	Shipping	CertMail	Total
Electronic Copy Fee	10	2.00	\$20.00	\$0.00	\$0.00	\$0.00	\$2.00	\$0.00	\$22.00
Affidavit Fee	1	25.00	\$25.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$25.00
Totals:			\$45.00	\$0.00	\$0.00	\$0.00	\$2.00	\$0.00	\$47.00
The copy fee rate reflects the average rate for all items copied.									
Pages 1 to 1 = \$20.00/pg Pages 2 to 20 = \$0.00/pg Pages 21 to 100 = \$1.00/pg Pages 101+ = \$0.50/pg									
MEMORIAL HOSPITAL AT GULFPORT has contracted with PHNS Inc - Hunter Account to provide medical information requested on GARY MCBAY. This request has been processed and the records are enclosed. We must receive your payment within 30 days of the invoice date. For questions regarding this invoice, call & phoneNumber & or write the address listed below. Checks returned for non-sufficient funds will be charged up to a \$0.00 fee.									
Online Payment: Conveniently and securely pay your invoice online at www.huntermedicalsystems.com									
Check: Please return a copy of this invoice with your payment and write the invoice number on your check. Make check payable to: PHNS Inc - Hunter Account, PO BOX 671281, Dallas, TX 75267-1281. Federal Tax I.D No. 72-1292247									
Credit Card: Pay online or mail this section to the address listed above or fax to 214-257-7173									
Invoice #: Patient Name: GARY MCBAY Amount to Charge: _____ Total Due: \$0.00 <input type="checkbox"/> Amex <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover					Print Name: _____ Address: _____ Address: _____ City, State, Zip: _____				

Dukes, Dukes, Keating & Faneca, P.A.

WILLIAM F. DUKES
(1927 - 2003)

Walter W. Dukes
Hugh D. Keating
Cy Faneca

Phillip W. Jarrell *
W. Edward Hatten, Jr.
Trace D. McRaney
Bobby R. Long

Je'Nell B. Blum **
Haley N. Broom
Jon S. Tiner
Matthew M. Williams
Adam B. Harris

* ALSO LICENSED IN TX
** ALSO LICENSED IN CA

2909 13th Street, Sixth Floor
Gulfport, Mississippi 39501
Telephone: 228-868-1111
Facsimile: 228-863-2886
www.ddkf.com

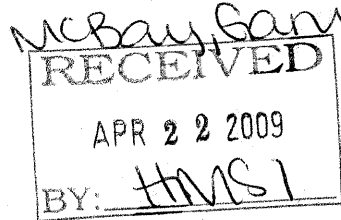
Gulfport Mailing Address:
Post Office Drawer W
Gulfport, Mississippi 39502
Toll Free: (888) 542-2034



Hattiesburg Office:
100 Dudley W. Conner Street
Hattiesburg, Mississippi 39401
Telephone: 601-583-0999
Facsimile: 601-583-0997

April 15, 2009

Dr. Larry Killebrew
Memorial Hospital
4500 13th St.
Gulfport, MS 39502-1810



Re: *Gary Brice McBay v. Harrison County Mississippi by and through its Board of supervisors; Harrison County Sheriff George Payne, in his official and individual capacity; Direct of Operations Major Wayne Payne, in his official and individual capacity; Director of Operations Major Wayne Payne, in his official and individual capacity; Director of Corrections Major Dianne Gaston Riley, in her official and individual capacity; Director of Professional Standards Unit Captain Steve Campbell, in his official and individual capacity; Supervisor of Booking Captain Rick Gaston, in his official and individual capacity; Corrections Officer Sergeant Ryan Teel, in his official and individual capacity; Corrections Officers John Doe 1-4 in their official and individual capacity; American Correctional Association and its Executive Director James A. Gondles, Jr. And employee(s) John and/or Jane Doe 1-3; Health Assurance LLC and its employee(s) John and/or Jane Doe 1-2*
Civil Action No. 1:07cv1205LG-JMR
Our File No. 1811.0119

To Whom It May Concern:

Our firm represents a defendant in a civil right lawsuit which has been filed by Gary Brice McBay.

Please forward to us all records you have reflecting Gary Brice McBay's treatment by you including, but not limited to, the following:

Copied By PEINS

Date: _____
Rep: _____
Dr: _____
DOS: _____

0531100375

- | | |
|---|--|
| 1. Questionnaires | 5. Surgical/Pathology Reports |
| 2. Histories | 6. All Hospital Records |
| 3. X-ray Reports | 7. Medical Reports and Summaries |
| 4. Office notes (handwritten and transcribed) | 8. Consultations |
| | 9. Any and all bills incurred for his/her care and treatment at your facility. |

Enclosed is a medical authorization form which complies with HIPAA.


Also enclosed is a Records Affidavit for your convenience in certification of these records. The Affidavit will need to be signed in front of a notary public for proper certification. Once the records have been obtained and the Affidavit has been executed, please forward same to me at the above listed address.

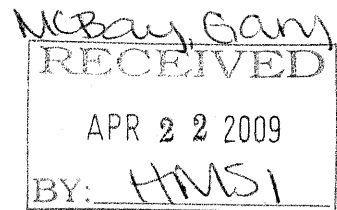
If there is a charge for this service, please forward a statement with the records; however, if the charge exceeds \$100, please contact me prior to processing this request.

Thank you in advance for your cooperation and attention in this matter.

Sincerely,

DUKES, DUKES, KEATING & FANCA, P.A.


Haley N. Broom



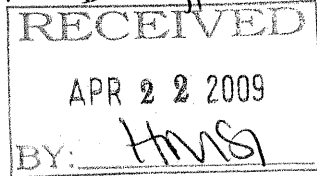
HNB/lc
Enclosures

cc: Michael Bruffey, Esquire

I hereby authorize Memorial Hospital to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requestor Name: Dukes, Dukes, Keating and Faneca, P.A.
P.O. Drawer W
Gulfport, MS 39502

Patient Name: Gary Brice McBay
Patient DOB: August 5, 1976
Patient Social Security Number: 458-95-4195
Patient Address: c/o Michael Bruffey
496 Vieux Marche, Suite 1
Biloxi, MS 39533



Disclose the following PHI for treatment dates (08/05/76) to Present.

- | | | | |
|---|--|--|--|
| <input checked="" type="checkbox"/> Abstract/Pertinent | <input checked="" type="checkbox"/> History and Physical | <input checked="" type="checkbox"/> Physician Orders | <input checked="" type="checkbox"/> Entire Chart |
| <input checked="" type="checkbox"/> Operative Report | <input checked="" type="checkbox"/> Progress Notes | <input checked="" type="checkbox"/> X-ray | <input checked="" type="checkbox"/> Billing |
| <input checked="" type="checkbox"/> ER Report | <input checked="" type="checkbox"/> Lab | <input checked="" type="checkbox"/> Consult | |
| <input checked="" type="checkbox"/> Other specified | <input checked="" type="checkbox"/> Discharge Summary | <input checked="" type="checkbox"/> Nurse Notes | |
| <input checked="" type="checkbox"/> Other Specified: All other such records in your possession, custody or control. | | | |

The above information is disclosed for the following purposes:

- ☒ Medical Care ☒ Legal ☐ Insurance ☐ Personal ☐ Other

X GBM I acknowledge, and hereby consent to such, that the release of information may contain alcohol
initials and drug abuse, psychiatric, HIV or genetic information

This authorization shall expire upon this expiration date: final disposition of Gary Brice McBay or five (5) years from the date of this authorization, whichever comes first
**If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

- I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Memorial Hospital. I understand that the revocation will not apply to information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.

X Gary Brice McBay
Signature of Patient/Legal Representative

4-6-09
Date

If signed by legal representative, relationship to patient: _____

Signature of Witness

Date

If signed by legal representative, relationship to patient: _____

Signature of Witness

Date

0331100375

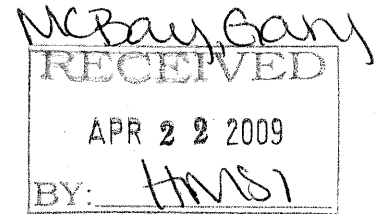
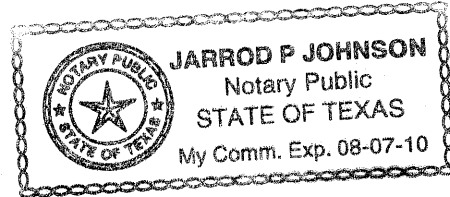
SWORN TO AND SUBSCRIBED BEFORE ME, this the 6 day of April, 2009.

NOTARY PUBLIC

My Commission Expires:

8-7-10

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.



F/C:S P/T:ERT

MCBAY, GARY B

05311-00375

11/07/05 11/07/05 1

E R PHYSICIAN

NO INSURANCE

GARY BRICE MCBAY
 300 VZ COUNTY ROAD 3506
 EDGEWOOD TX 75117-3466

04/29/09

	CODE	DESCRIPTION	QTY	
	***250	PHARMACY		
11/07	002834	TETANUS-DIPHThERIA TOXOIDS-TD	1	49.90
		AREA TOTAL ***		49.90
	***272	STERILE SUPPLY		
11/07	013013	KIT URINE CULTURE CLEAN CATCH	1	48.50
		AREA TOTAL ***		48.50
	***309	OTHER LABORATORY		
11/07	075164	DRUG SCREEN-URINE RAPID (6 DRUGS)	1	500.60
		AREA TOTAL ***		500.60
	***351	CT SCAN/HEAD		
11/07	050017	CT BRAIN WITHOUT IV CONTRAST	1	1,693.50
11/07	050023	CT ORBIT/SELLA/P FOSSA/IAC W/O CX	1	1,693.50
		AREA TOTAL ***		3,387.00
	***450	EMERGENCY ROOM		
11/07	000100	INJECTION SQ/IM	1	33.60
11/07	060209	LEVEL VB-W DIAG TEST/PROCEDURE	1	1,008.10
		AREA TOTAL ***		1,041.70
	***981	PROFESSIONAL FEES E/R		
11/07	069321	E&M LEVEL III	1	230.40
		AREA TOTAL ***		230.40

TOTAL CHARGES 5,258.10

TOTAL PAYMENTS/ADJUSTMENTS 0.00

5,258.10

0.00

5,258.10

Memorial**PATIENT REGISTRATION**

E15 CP

MR	PATIENT NAME										ROOM NO.	ACCOUNT NO.
0000359017	MCBAY, GARY BRICE										FC S -	05311-00375
PATIENT ADDRESS										CITY	STATE	ZIP CODE
1109 SILVER CREEK										DE SOTO	TX	75115
SOCIAL SECURITY NO	ADMISSION DATE	ADM HOUR	ADM TYPE	ADM SOURCE	ACCD CODE	DISCHARGE DATE	MED SV CD	ADM. PHY.	ATT. PHY.	ATT. PHYS. NAME		
458-95-4195	11/07/05	1502	1	7		ERT ER		999	999	PHYSICIAN, E R		
PATIENT PHONE	BIRTHDATE	AGE	SEX	ORIGIN	MARITAL	RELIGION	CHURCH PREFERENCE					
(972)223-2083	08/05/76	29Y	M	4	S	UAF	UNAFFILIATED					
SPOUSE'S NAME		NEAREST RELATIVE					RELATIONSHIP		PATIENT'S MAIDEN NAME			
IN CASE OF EMERGENCY NOTIFY		RELATIONSHIP		ADDRESS			CITY		STATE ZIP CODE			
MCBAY, GARY		FATHER		1109 SILVER CREEK			DE SOTO					
PRIMARY EMERGENCY PHONE	ALT EMERGENCY PHONE		PATIENT EMPLOYER									
(972)223-2083			SELF									
ADDRESS OF EMPLOYER			CITY			STATE			ZIP CODE		PHONE	
OTHER EMPLOYER			ADDRESS			CITY			STATE ZIP CODE			
MCBAY, GARY BRICE												
GUARANTOR EMPLOYER			PHONE			GUARANTOR SOCIAL SECURITY NO.						
SELF						458-95-4195						
ADDRESS OF GUARANTOR EMPLOYER			CITY			STATE			ZIP CODE			
ALTERCATION			ACCIDENT			DATE			TIME			
						ALTERCATION W/SHERIFF DE			11/06/05 2000			
NAME OF INSURANCE NO 1			NAME OF INSURANCE NO 2			NAME OF INSURANCE NO 3						
GROUP NAME			GROUP NAME			GROUP NAME						
GROUP NO. / POLICYHOLDER			GROUP NO. / POLICYHOLDER			GROUP NO. / POLICYHOLDER						
STREET ADDRESS			STREET ADDRESS			STREET ADDRESS						
CITY STATE ZIP CODE			CITY STATE ZIP CODE			CITY STATE ZIP CODE						
Admitting Diagnosis (Record here or on Physical Examination)												
PRINCIPAL Diagnosis												
Complications and/or Additional Diagnosis (List All)												
Principal Procedure												
All Other Procedures												
PRINTED BY: slh9337												
DATE 5/19/2009												
Consultation with												
<input type="checkbox"/> ALIVE <input type="checkbox"/> AMA <input type="checkbox"/> DIED DISCHARGE STATUS <input type="checkbox"/> TRANSFER (AUTOPSY <input type="checkbox"/> YES <input type="checkbox"/> NO)												



T 10

CONSENT FOR ADMISSION TO HOSPITAL AND MEDICAL TREATMENT

I, Gary Brice McBAY, give permission for such examination and treatment as the doctor(s) considers necessary or advisable for the care of MCBAY, GARY BRICE (Patient's Name).

I understand:

1. That examination and treatment may include x-rays, drawing blood, medical/surgical care, medicines, anesthesia, or other healing measures.
2. That unexpected situations may arise and I now give permission, in the event I am later unavailable or unable to consent, for the doctor(s) to do what is necessary to save the health, or life, of the above named patient.
3. If I/the above named patient deliver a baby during this hospital stay, I give permission for such examination and treatment of that baby as the doctor(s) considers necessary and advisable.
4. The practice of medicine and surgery is not an exact science. There are no guarantees of success.
5. I have read and do understand this consent. I have had a chance to ask questions. The MHG staff answered my questions.

OTHER TERMS OF ADMISSION

I understand:

1. Memorial Hospital at Gulfport will send me/the above named patient a bill.
2. Each physician specialist who examines or treats me or the above named patient will send a separate bill.
3. Physicians working in the Hospital Emergency Department are not employees of the hospital. They work for Emergency Care Specialists of Mississippi, Ltd., a separate organization which is an independent contractor to Memorial Hospital at Gulfport.
4. I am responsible for calling my insurance company before admission. The insurance company may reduce my benefits if I do not follow procedures. The hospital will contact the insurance company only as a courtesy.
5. If I am in a Managed Care Plan requiring approval of a primary care physician (PCP), the hospital will contact the PCP for instructions. My insurer may not pay if I receive services without their approval. In this case, I may be personally responsible for all charges for these services.
6. Memorial Hospital will not deny or delay treatment for any emergency medical condition in order to contact or receive approval from my insurance company or any PCP.

WAIVER OF CLAIM FOR LOSS OR DAMAGE TO PERSONAL PROPERTY

I understand:

1. I may place my personal property in the Hospital safe.
2. I am responsible for loss of or damage to personal property that I do not place in the Hospital safe.

Witness W. H. H. H. Date NOV 16 2005 Time 3:04 Signature of patient or person permitted to sign for patient G. Brice McBAY Date NOV 16 2005

AUTHORIZATION TO RELEASE INFORMATION TO INSURER & ASSIGNMENT

I give permission to the Hospital to release medical information needed to process any claim related to this hospital stay against any of my insurance companies, including automobile or other liability insurance companies. MHG can release this medical information only to the insurance company or any third party payor involved in this claim. Third party payors may be Medicare, Medicaid, CHAMPUS, CHAMPVA, automobile or other liability insurance, or any worker compensation plan. This permission is good for the time provided in MHG's Health Information Management Department policy unless I deliver to the Hospital written notice of cancellation.

I assign all insurance benefits and all third party claims up to the amount owed to Memorial Hospital at Gulfport and to any physicians who provide services to me or the above named patient. I direct third party payors to pay all benefits directly to MHG and these physicians.

I have given current and correct information about my insurance or other benefit status to the Hospital.

Witness W. H. H. H. Date NOV 16 2005 Signature of patient or person permitted to sign for patient G. Brice McBAY Date NOV 16 2005

FINANCIAL AGREEMENT AND GUARANTY OF PAYMENT

In consideration of services rendered the above named patient, I unconditionally guarantee payment for services not covered by insurance or a benefit program while a patient in Memorial Hospital at Gulfport. I guarantee this payment within 60 days of final billing. If I do not pay in full, within that time, MHG may refer the bill to an attorney or collection agency. If the bill is referred to an attorney, either by MHG or by a collection agency, I will be responsible for attorneys' fees of up to 33 1/3% in addition to the amount of the bill and legal interest from date 60 days after final billing. I understand that the Hospital has the right to examine credit bureau files for financial information on unpaid debts. MHG may inform any credit bureau of any hospital bill not paid within 60 days of final billing.

I have read and understand this financial agreement. I have had a chance to ask questions. The MHG staff answered my questions.

Witness W. H. H. H. Date NOV 16 2005 Signature of Patient or Guarantor of Account G. Brice McBAY Date NOV 16 2005
Relationship to Patient _____

IF PATIENT IS UNABLE TO CONSENT TO THE FOREGOING OR IS A MINOR, COMPLETE THE FOLLOWING:

PATIENT IS A MINOR _____ YEARS OF AGE / IS UNABLE TO CONSENT BECAUSE _____

Witness _____ Date ____/____/____ Person Permitted to Sign for Patient _____ Date ____/____/____

Important Message from Medicare received: _____

Signature of Patient _____

Clerk Initials _____

Date _____



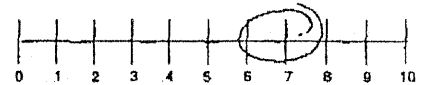

Consent for Admission
to Hospital and
Medical Treatment

PATIENT INFORMATION

ERT ERT -
MCBAY, GARY BRICE
11/07/2005 MR 0000359017
PHYSICIAN, E R
DOB 08/05/1976 0531100375
M 29Y



1720C

Name <u>McBay G Brice</u>		DOB <u>8-5-96</u>		Age <u>29</u>	
Triage Level		<input type="checkbox"/> Emergent Priority <input checked="" type="checkbox"/> Urgent Priority <input type="checkbox"/> Non-Urgent Priority		Emotional Status: <input type="checkbox"/> Comatose <input checked="" type="checkbox"/> Calm <input type="checkbox"/> Anxious <input type="checkbox"/> Combative <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Hostile <input type="checkbox"/> Other:	
<input type="checkbox"/> 24-72 Hour Return <input type="checkbox"/> Same Complaint <input checked="" type="checkbox"/> New Complaint <input type="checkbox"/> Call Back		On the Job Accident: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date: _____ Time of Event: _____		Mode of Arrival: <input type="checkbox"/> W/C <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Carried <input type="checkbox"/> Ambulance	
Arrived With: <input type="checkbox"/> Friend <input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input checked="" type="checkbox"/> Parent		Treatment Prior to Arrival: <input type="checkbox"/> None <input type="checkbox"/> Yes: <input type="checkbox"/> Ice <input type="checkbox"/> IV <input type="checkbox"/> ACLS <input type="checkbox"/> O2 <input type="checkbox"/> Spine Board/C-Collar <input type="checkbox"/> Monitor <input type="checkbox"/> Splint/dressing <input type="checkbox"/> Other			
Visual Acuity RT 20/_____ LT 20/_____ Both 20/_____ TET Tox <u>Under 3</u> LMP <u>3</u> WL <u>1</u> HL <u>1</u> <input type="checkbox"/> Actual <input checked="" type="checkbox"/> Estimate		TB Screen <input type="checkbox"/> Persistent Cough > 2 weeks <input type="checkbox"/> Wt Loss <input type="checkbox"/> Hx of TB <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Anorexia <input checked="" type="checkbox"/> No Symptoms <input type="checkbox"/> In Foreign Country Recently			
Date <u>11/2/05</u> Time <u>1442</u> Chief Complaint: (In Patient's Words) <u>State averts last p - hit i just all</u> <u>one leg. 90 qd w/ p. Attention to face</u> <u>abuse. Blackens eye</u> RN Signature <u>[Signature]</u>		PAIN ASSESSMENT <input type="checkbox"/> None <input type="checkbox"/> Pt Uncooperative <input type="checkbox"/> Unable to assess due to acuity Pain now: (circle) <u>7</u> For PEDS, use faces scale; document as 0-10. 			
Private Physician(s): <input type="checkbox"/> STAT (ED) Placement to Room # _____ Reported to _____ <input type="checkbox"/> To Lobby after triage - Awaiting Bed Availability <input type="checkbox"/> To Room # <u>745</u> at <u>1450</u> Report to _____ <input type="checkbox"/> LWBS at _____ <input type="checkbox"/> Refusal Obtained		Pain Assessment 			
Social History: Lives - <input type="checkbox"/> Alone <input type="checkbox"/> N.H. <input checked="" type="checkbox"/> Family <input type="checkbox"/> Homeless Smoker - <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PPD ETOH Use - <input type="checkbox"/> Yes <input type="checkbox"/> No Abuse - <input type="checkbox"/> Yes <input type="checkbox"/> No		Past Surgical History: _____ _____ _____			
Past Medical History: Family Patient Family Patient <input type="checkbox"/> Arthritis <input type="checkbox"/> Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> Lung Disease <input type="checkbox"/> Cancer <input type="checkbox"/> COPD <input type="checkbox"/> CVA <input type="checkbox"/> Bronchitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Nerves <input type="checkbox"/> GI <input type="checkbox"/> Back Problems <input type="checkbox"/> Ulcer <input type="checkbox"/> Seizures <input type="checkbox"/> Glaucoma <input type="checkbox"/> PVD <input type="checkbox"/> Heart Disease <input type="checkbox"/> Mental <input type="checkbox"/> Angina <input type="checkbox"/> Renal <input type="checkbox"/> CAD <input type="checkbox"/> Thyroid <input type="checkbox"/> Hepatitis <input type="checkbox"/> None <input type="checkbox"/> HIV		Initial Vitals BP <u>124/90</u> <input type="checkbox"/> NIBP <input type="checkbox"/> Audible <input type="checkbox"/> Palpable Pulse <u>124-116</u> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Weak Resp <u>18</u> <input type="checkbox"/> Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored Temperature <u>98</u> <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Axillary SpO2 <input type="checkbox"/> Room Air <u>97%</u> <input type="checkbox"/> O2 at _____ L/min		ALLERGIES <input type="checkbox"/> NONE KNOWN Food, Medication, Latex, Tape, Iodine, Other 1. <u>Myocardial</u> 2. <u>Penicillin</u> 3. _____	
Comments: <u>hyperphagia</u> <u>fx nose</u> <u>on meds</u>		Mental Status <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Oriented X3 <input type="checkbox"/> Combative <input type="checkbox"/> Lethargic <input type="checkbox"/> Drowsy <input type="checkbox"/> Unresponsive <input type="checkbox"/> Disoriented			
Special Needs or Physical Ability Needs <input type="checkbox"/> N/A <input type="checkbox"/> Blind Y/N Interpreter <input type="checkbox"/> Foreign language Interpreter		Speech <input checked="" type="checkbox"/> Coherent <input type="checkbox"/> Incoherent <input type="checkbox"/> Slurred <input type="checkbox"/> Silent Skin <input checked="" type="checkbox"/> Normal Pink <input type="checkbox"/> Ashen <input type="checkbox"/> Dark Pigment <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed <input type="checkbox"/> Pale <input type="checkbox"/> Jaundiced Skin Temp <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Cool			
Respiratory <input type="checkbox"/> Regular <input type="checkbox"/> Labored <input type="checkbox"/> Shallow <input type="checkbox"/> Retractive <input type="checkbox"/> Absent Pupils <input type="checkbox"/> N/A <input checked="" type="checkbox"/> Per <input type="checkbox"/> Unequal <input type="checkbox"/> RT <input type="checkbox"/> LT		Teeth/Mouth problems <input type="checkbox"/> Deaf Y/N Interpreter <input type="checkbox"/> Financial <input type="checkbox"/> Emotional <input type="checkbox"/> Spiritual <input type="checkbox"/> Cultural		Patient Information <u>Cr brown</u> <u>Crookets/505</u> <u>do</u>	

Memorial
 Building a Healthier Community

**Emergency
 Department
 Nursing
 Record**

PRINTED BY: aeq2177
 DATE 11/8/2005

MCBAY, GARY BRICE
 PHYSICIAN, E R
 MR 0000359017
 11/07/2005
 DOB 08/05/1976
 ERT M 29Y
 0531100375

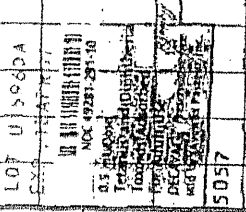
Patient Name _____ Account # _____ Date: _____

Time	T	P	R	BP	Time	T	P	R	BP

Ongoing Assessment Treatment

1435P - multiple bruises - blackened eyes Lt > Rt happened early AM at Police Station - nose is not straight abrasion across it forehead abrasion on Rt forehead elbow minor knee contusions - Dr. Killebrew to see pt @ 1510 CT's of joints & brain ordered - as a precaution 1535 pt to CT Ambulance EMT, 1555 pt to Rm from CT & EMT (732) URS obtained & delivered to lab. Stomach incase of family to return tomorrow for results - pt Alert & 3 fully ambulatory. No acute changes noted.

Time	Medication	Dose	Mode	Site	Signature	Time	Medication	Dose	Mode	Site	Signature
1530	DTG	5cc	IM		<i>[Signature]</i>						



LOT U15960A
EXP 18APR07

MCBAY, GARY BRICE
PHYSICIAN, E R
MR 0000359017
11/07/2005
DOB 08/05/1976
ERT M 29Y
0531100375

I N F U S I O N	Amt	Solution	Additive	Device	Site	Rate	Start	Stop	Total Amount	Signature	Intake	Output

Disposition **1732 AM/PM**

☐ Admitted Time Room No. Ready Room Time ☒ Discharged via
☒ Ambulatory ☐ Wheelchair
☐ In Arms ☐ Ambulance

PRINTED BY: aeq2177

DATE 11/8/2005

HISTORY AND PHYSICAL		Time:
CC/PHI:	FMH:	
SH:		
<p>29yo involved in altercation E</p> <p>police last pm -</p> <p>Don chest, arms, face</p>		
<p>PE</p> <p>Lungs clear</p> <p>CV RSR</p> <p>NO intst</p> <p>Bruising over arm bilaterally -</p> <p>Bruising chest</p> <p>large (2) periorbital hematomas</p> <p>Bruising under eye</p>		
<p>LAB:</p>		
<p>X-RAY</p>		
<p>EKG</p>		
<p>U.S./C.T.</p>		
<p>DIAGNOSIS: Nasal fracture</p>		
<input checked="" type="checkbox"/> May Discharge <input type="checkbox"/> Admit <p>Time 1832</p>	<input type="checkbox"/> Transfer <input type="checkbox"/> AMA	<p>Condition on Discharge</p> <p><input checked="" type="checkbox"/> Stable</p>
<p>I HAVE REVIEWED THE NURSES ASSESSMENT AND HISTORY</p> <p>Physician's Signature: <i>[Signature]</i></p>		
<p>Patient Instructions</p> <p><input type="checkbox"/> Sprain & Fracture, Severe Bruises <input type="checkbox"/> Medications <input type="checkbox"/> Head Inj (adult) <input type="checkbox"/> Fever <input type="checkbox"/> Back/Neck Inj <input type="checkbox"/> Vomiting/Diarrhea <input type="checkbox"/> Common Cold/Viruses</p> <p><input type="checkbox"/> Sedation Instruction <input type="checkbox"/> Reducing High Fever <input type="checkbox"/> Orthopedic Appliance <input type="checkbox"/> Head Inj (Child) <input type="checkbox"/> Eye Inj <input type="checkbox"/> Wound Care/Animal Bite <input type="checkbox"/> Burns</p> <p><input type="checkbox"/> Other</p>		
<p>DISCHARGE INSTRUCTIONS:</p> <p>Take meds as ordered</p> <p>return as needed</p>		
<p>Follow Up</p> <p><input type="checkbox"/> Make an appointment to see your regular physician</p> <p><input type="checkbox"/> Follow-up Visit in Emergency Department</p> <p><input type="checkbox"/> Have Sutures Removed in _____ Days</p>		
<p>PATIENT(S)O VERBALIZED UNDERSTANDING OF INSTRUCTIONS</p> <p>Nurse Signature: <i>[Signature]</i></p>		<p>I HAVE READ AND UNDERSTAND AND INSTRUCTIONS AND HAVE RECEIVED A COPY OF THEM</p> <p>Patient Signature: <i>[Signature]</i></p>



ROS: • if neg.

Gen: 0

Card: 0

Resp: 0

Renal: 0

End: 0

GI: 0

Neuro: 0

Eye: 0

ENT: 0

Skin: 0

Psych: 0

Ms/Stl: 0

ORDERS

Test Order Tm/Int.

Ch. M. 3

Get out 3

2/11/05

Nurse Order Tm/Int.

186.5ca 1/11/05

Memorial

Building a Healthier Community

Emergency
Department
Physician
Record

PRINTED BY: 2177
DATE: 11/8/2005

MCBAY, GARY BRICE
PHYSICIAN, E R
MR 0000359017



11/07/2005
DOB 08/05/1976
ERT M 29Y
0531100375

MCBAY, GARY BRICE

DOB: 08/05/76

AGE: 29Y

MR# G0000359017

CI# 834729

ACCOUNT # 0531100375

SERV: ERT

PT TYPE: ERT LOC: ERT

EXAM DATE: 11/07/05

ORD: KILLEBREW, LARRY MD

ADM: PHYSICIAN, E R MD

ATT: PHYSICIAN, E R MD

Chk-in #	Order	Exam
834729	0001	50017 CT BRAIN WITHOUT IV CONTRAST
Ord Diag: trauma		

CT BRAIN WITHOUT IV CONTRAST:

CLINICAL HISTORY PROVIDED: Altercation with head trauma.

Multiple sequential sections were obtained through the brain and there is a large left temporoparietal scalp hematoma. There is no associated fracture.

Brain attenuation is normal with no focal ischemic infarct, mass, or hemorrhage. Ventricular system is normal and midline structures are midline. There is no acute extraaxial fluid accumulation.

There is some mucosal thickening of the ethmoid air cells bilaterally.

IMPRESSION:

THERE IS A RELATIVELY LARGE LEFT TEMPOROPARIETAL SCALP HEMATOMA OR CONTUSION. THERE IS NO ASSOCIATED FRACTURE OR ACUTE INTRACRANIAL ABNORMALITY.

THERE IS SOME MUCOSAL THICKENING OF THE ETHMOID AIR CELLS BILATERALLY.

/Read By/ MILTON R RAINES, M.D.

/Released By/ MILTON R RAINES, M.D.

PRELIMINARY UNLESS RELEASED

11/07/05 2016

Typed By: SKY

Typed On: 11/07/05 1647

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: aeq2177

DATE 11/8/2005

RADIOLOGY REPORT

MCBAY, GARY BRICE DOB: 08/05/76 AGE: 29Y
MR# G0000359017 CI# 834748 ACCOUNT # 0531100375
SERV: ERT
PT TYPE: ERT LOC: ERT EXAM DATE: 11/07/05
ORD: KILLEBREW, LARRY MD ADM: PHYSICIAN, E R MD
ATT: PHYSICIAN, E R MD

Chk-in # Order Exam
834748 0003 50023 CT ORBIT/SELLA/P FOSSA/IAC W/O CX
Ord Diag: ALTERCATION

CT OF THE ORBITS:

CLINICAL HISTORY PROVIDED: Altercation. Orbital injury.

Multiple sequential sections were obtained through the orbits and there is comminuted nasal bone fracture with deviation of the nasal septum to the right posteriorly with spurring which is chronic in appearance. I do not see a definite orbital fracture. There is mucosal thickening ethmoid air cells bilaterally and frontal sinuses more on right than left. There is also air within the soft tissues over the anterior and lateral right maxillary sinus although no definite orbital floor or sinus fractures are seen. There is soft tissue swelling over the orbits and face bilaterally.

IMPRESSION:

COMMINUTED NASAL BONE FRACTURE. MUCOSAL THICKENING BILATERAL ETHMOID AND FRONTAL SINUSES WHICH IS MORE PROMINENT ON RIGHT THAN THE LEFT, PROBABLY RELATED TO TRAUMA AND MILD BLEEDING. SOFT TISSUE AIR OVER THE RIGHT MAXILLARY SINUS BUT NO DEFINITE ORBITAL OR MAXILLARY FRACTURE IS IDENTIFIED. PROMINENT DEVIATION OF THE NASAL SEPTUM APPEARS CHRONIC.

/Read By/ MILTON R RAINES, M.D.

/Released By/ MILTON R RAINES, M.D.

PRELIMINARY UNLESS RELEASED

11/07/05 2016

Typed By: SKY

Typed On: 11/07/05 1650

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: aeq2177

DATE 11/8/2005

***** MHG PATIENT INQUIRY Demand Report *****

Patient: MCBAY, GARY BRICE
 Age: 29Y Sex: M DOB:08/05/76
 MR#: 0000359017
 Admit Phys: PHYSICIAN, E R DE
 Attend Phys: KILLEBREW, LARRY MD

Loc: ERT Facility: ER Trauma
 Admit#: 0531100375
 Order Phys: KILLEBREW, LARRY MD
 Consult Phys:

*** PI DEMAND REPORT ***

RunID: R1621536
 Reported: 11/08/05 10:19

***** TOXICOLOGY *****

	11/07/05 17:30	REF RANGE	UNITS
Amphet	Negative		
Barb	Negative	Negative	
Benzo	Negative	Negative	
Cannab	Negative	Negative	
Cocaine	Negative	Negative	
Opiate	Negative	Negative	
Comment	See Note ¹	Negative	

¹Results are for medical / screening purposes only. Confirmation testing by reference lab available if ordered within 48 hours

Patient: MCBAY, GARY BRICE

Page 1 of 1

Clinical / Pathology Laboratory * Memorial Hospital at Gulfport * 4500 13th Street * Gulfport, MS 39501
 Phone: 228-575-2300 * Fax: 228-575-2387

MHG Dept. of Pathology: P. Saccoccia, Jr., MD C. Slonaker, MD M.J. Gandour, MD J. Causey, MD

***** TOXICOLOGY *****





*1720C

Name <u>McBay G Brice</u>		DOB <u>8-5-76</u>		Age <u>29</u>	
Triage Level	<input type="checkbox"/> Emergent Priority	<input checked="" type="checkbox"/> Urgent Priority	<input type="checkbox"/> Non-Urgent Priority	Emotional Status:	<input type="checkbox"/> Comatose <input type="checkbox"/> Anxious <input type="checkbox"/> Hostile <input checked="" type="checkbox"/> Calm <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Other:
<input type="checkbox"/> 24-72 Hour Return <input type="checkbox"/> Same Complaint <input checked="" type="checkbox"/> New Complaint <input type="checkbox"/> Call Back	On the Job Accident: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date: _____ Time of Event: _____	Mode of Arrival: <input type="checkbox"/> W/C <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Carried <input type="checkbox"/> Ambulance	Arrived With: <input type="checkbox"/> Friend <input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input checked="" type="checkbox"/> Parent	Treatment Prior to Arrival: <input type="checkbox"/> None <input type="checkbox"/> Yes: <input type="checkbox"/> Ice <input type="checkbox"/> IV <input type="checkbox"/> ACLS <input type="checkbox"/> O2 <input type="checkbox"/> Spine Board/C-Collar <input type="checkbox"/> Monitor <input type="checkbox"/> Splint/dressing <input type="checkbox"/> Other	
Visual Acuity RT 20/ LT 20/ Both 20/	TET Tox	LMP <u>3</u>	Wt. <u>1</u>	Ht. <u>1</u>	TB Screen <input type="checkbox"/> Persistent Cough > 2 weeks <input type="checkbox"/> Wt Loss <input type="checkbox"/> Hx of TB <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Anorexia <input checked="" type="checkbox"/> No Symptoms <input type="checkbox"/> In Foreign Country Recently
Date <u>11/2/05</u>	Time <u>1442</u>	Chief Complaint: (In Patient's Words) <u>State arrested last p - hit i just all</u> <u>one hly. 40 gms hly. par. Abrasion to face</u> <u>abrasion. Blackened eye</u>		PAIN ASSESSMENT <input type="checkbox"/> None <input type="checkbox"/> Pt Uncooperative <input type="checkbox"/> Unable to assess due to acuity Pain now: (circle) <u>6</u> For PEDS, use faces scale; document as 0-10. 	
Private Physician(s):	<input type="checkbox"/> STAT (ED) Placement to Room # _____ Reported to _____ <input type="checkbox"/> To Lobby after triage - Awaiting Bed Availability <input type="checkbox"/> To Room # <u>225</u> at <u>1450</u> Report to _____ <input type="checkbox"/> LWBS at _____ <input type="checkbox"/> Refusal Obtained		How long have you been in pain? <u>earliest</u> Location(s) (specify each site) <u>face elbow</u> <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input type="checkbox"/> Other <u>sharp</u> What worsens pain? <u>rough</u> What relieves pain? <u>ice</u> Pain interferes with: <input checked="" type="checkbox"/> Function <input type="checkbox"/> Sleep <input type="checkbox"/> Appetite <input type="checkbox"/> Other What level of pain would be able to tolerate (Ex. Would allow you to sleep, perform ADLs, move post-op, etc.) <u>4</u>		
Social History: Lives - <input type="checkbox"/> Alone <input type="checkbox"/> N.H. <input checked="" type="checkbox"/> Family <input type="checkbox"/> Homeless Smoker - <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PPD ETOH Use - <input type="checkbox"/> Yes <input type="checkbox"/> No Abuse - <input type="checkbox"/> Yes <input type="checkbox"/> No		Past Surgical History:			
Past Medical History: Family Patient <input type="checkbox"/> Arthritis <input type="checkbox"/> Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> Lung Disease <input type="checkbox"/> Cancer <input type="checkbox"/> COPD <input type="checkbox"/> CVA <input type="checkbox"/> Bronchitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Nerves <input type="checkbox"/> GI <input type="checkbox"/> Back Problems <input type="checkbox"/> Ulcer <input type="checkbox"/> Seizures <input type="checkbox"/> Glaucoma <input type="checkbox"/> PVD <input type="checkbox"/> Heart Disease <input type="checkbox"/> Mental <input type="checkbox"/> Angina <input type="checkbox"/> Renal <input type="checkbox"/> CAD <input type="checkbox"/> Thyroid <input type="checkbox"/> Hepatitis <input type="checkbox"/> None <input type="checkbox"/> HIV		Initial Vitals BP <u>124/92</u> <input type="checkbox"/> NIBP <input type="checkbox"/> Audible <input type="checkbox"/> Palpable Pulse <u>124-116</u> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Weak Resp <u>18</u> <input type="checkbox"/> Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored Temperature <u>98</u> <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Axillary SpO2 <input type="checkbox"/> Room Air <input type="checkbox"/> O2 at _____ L/min <u>99%</u>			
Comments: <u>hyperphagia</u> <u>fx nose</u> <u>on meds</u>		ALLERGIES <input type="checkbox"/> NONE KNOWN Food, Medication, Latex, Tape, Iodine, Other 1. <u>Myces</u> 2. <u>Penicillin</u> 3.			
Special Needs or Physical Ability Needs <input type="checkbox"/> N/A <input type="checkbox"/> Blind Y/N Interpreter <input type="checkbox"/> Foreign language Interpreter		Mental Status <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Oriented X 3 <input type="checkbox"/> Combative <input type="checkbox"/> Lethargic <input type="checkbox"/> Drowsy <input type="checkbox"/> Unresponsive <input type="checkbox"/> Disoriented Speech <input checked="" type="checkbox"/> Coherent <input type="checkbox"/> Incoherent <input type="checkbox"/> Slurred <input type="checkbox"/> Silent Respiratory <input type="checkbox"/> Regular <input type="checkbox"/> Labored <input type="checkbox"/> Shallow <input type="checkbox"/> Retractive <input type="checkbox"/> Absent Pupils <input type="checkbox"/> N/A <input checked="" type="checkbox"/> Pert <input type="checkbox"/> Unequal <input type="checkbox"/> RT _____ <input type="checkbox"/> LT _____ Skin Color <input checked="" type="checkbox"/> Normal Pink <input type="checkbox"/> Ashen <input type="checkbox"/> Dark Pigment <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed <input type="checkbox"/> Pale <input type="checkbox"/> Jaundiced Skin <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Diaphoretic Skin Temp <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Cool			

Memorial
 Building a Healthier Community

Emergency
 Department
 Nursing
 Record

PRINTED BY: slh9337
 DATE: 5/19/2009

MCBAY, GARY BRICE
 PHYSICIAN, E R
 MR 0000359017

11/07/2005
 DOB 08/05/1976
 ERT M 29Y

0531100375

Patient Name _____

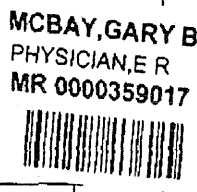
Account # _____

Date: _____

Time	T	P	R	BP	Time	T	P	R	BP

Ongoing Assessment Treatment

1455H Multiple bruises - blackened eyes Lt > Rt happened early AM at Police Station - nose is not straight abrasion across Lt forehead abrasion on Rt forehead elbow minor knee contusions - Dr. Killebrew to see pt @ 1510 CTS for ketorolac ordered - also held at 1535 to ECT Ambulance DT, 1555 to Rm from CT & H, EDT (732) was obtained & delivered to lab to come in case of family to return tomorrow for results - pt Hx 60 x 3 fully ambulatory - no acute Ct raised

Time	Medication	Dose	Mode	Site	Signature	Time	Medication	Dose	Mode	Site	Signature	
1500	dt 6	5cc	IM		<i>[Signature]</i>							
LOT U 5960A EXP 18APR07	LOT U 5960A EXP 18APR07											
 <p>MCBAY, GARY BRICE PHYSICIAN, E R MR 0000359017 11/07/2005 DOB 08/05/1976 ERT M 29Y 0531100375</p>												
I	Amt	Solution	Additive	Device	Site	Rate	Start	Stop	Total Amount	Signature	Intake	Output
N												
F												
U												
S												
I												
O												
N												
Disposition 1732 AM/PM	<input type="checkbox"/> Admitted Time	Room No.	Ready Room Time	<input checked="" type="checkbox"/> Discharged via	<input checked="" type="checkbox"/> Ambulatory	<input type="checkbox"/> Wheelchair						
				<input type="checkbox"/> In Arms	<input type="checkbox"/> Ambulance							

PRINTED BY: slh9337

DATE 5/19/2009

Memorial

Emergency
Department
Physician
Record

PRINTED BY: slh9337
DATE: 5/19/2009

MCBAY, GARY BRICE
PHYSICIAN, E R
MR 0000359017

11/07/2005
DOB 08/05/1976
ERT M 29Y
0531100375

* * * * * MHG Cumulative Summary Report * * * * *

Patient: MCBAY, GARY BRICE	Admit Loc: ERT	Facility: ER Trauma
Age: 29Y Sex: M		** MEDICALR DISCHARGE REPORT **
DOB: 08/05/76		*** PERMANENT REPORT - DO NOT DISCARD ***
MR#: 0000359017	Admit#: 0531100375	Dsch Date: 11/07/05
Admit Phys: PHYSICIAN, E R DE	Order Phys: KILLEBREW, LARRY MD	RunID: R1624489
Attend Phys: KILLEBREW, LARRY MD	Consult Phys:	Reported: 11/10/05 03:11

***** TOXICOLOGY *****

	11/07/05 17:30	REF RANGE	UNITS
Amphet	Negative	Negative	
Barb	Negative	Negative	
Benzo	Negative	Negative	
Cannab	Negative	Negative	
Cocaine	Negative	Negative	
Opiate	Negative	Negative	
Comment	See Note ¹		

¹Results are for medical / screening purposes only. Confirmation testing by reference lab available if ordered within 48 hours..

Patient: MCBAY, GARY BRICE

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PRINTED BY: slh9337

DATE ***** 5/13/2009 *****
***** TOXICOLOGY *****

MCBAY, GARY BRICE DOB: 08/05/76 AGE: 29Y
MR# G0000359017 CI# 834729 ACCOUNT # 0531100375
SERV: ERT
PT TYPE: ERT LOC: ERT EXAM DATE: 11/07/05
ORD: KILLEBREW, LARRY MD ADM: PHYSICIAN, E R MD
ATT: PHYSICIAN, E R MD

Chk-in # Order Exam
834729 0001 50017 CT BRAIN WITHOUT IV CONTRAST
Ord Diag: trauma

CT BRAIN WITHOUT IV CONTRAST:

CLINICAL HISTORY PROVIDED: Altercation with head trauma.

Multiple sequential sections were obtained through the brain and there is a large left temporoparietal scalp hematoma. There is no associated fracture.

Brain attenuation is normal with no focal ischemic infarct, mass, or hemorrhage. Ventricular system is normal and midline structures are midline. There is no acute extraaxial fluid accumulation.

There is some mucosal thickening of the ethmoid air cells bilaterally.

IMPRESSION:

THERE IS A RELATIVELY LARGE LEFT TEMPOROPARIETAL SCALP HEMATOMA OR CONTUSION. THERE IS NO ASSOCIATED FRACTURE OR ACUTE INTRACRANIAL ABNORMALITY.

THERE IS SOME MUCOSAL THICKENING OF THE ETHMOID AIR CELLS BILATERALLY.

/Read By/ MILTON R RAINES, M.D.
/Released By/ MILTON R RAINES, M.D.

PRELIMINARY UNLESS RELEASED

11/07/05 2016
Typed By: SKY
Typed On: 11/07/05 1647

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

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DATE 5/19/2009

MCBAY, GARY BRICE DOB: 08/05/76 AGE: 29Y
MR# G0000359017 CI# 834748 ACCOUNT # 0531100375
SERV: ERT
PT TYPE: ERT LOC: ERT EXAM DATE: 11/07/05
ORD: KILLEBREW, LARRY MD ADM: PHYSICIAN, E R MD
ATT: PHYSICIAN, E R MD

Chk-in # Order Exam
834748 0003 50023 CT ORBIT/SELLA/P FOSSA/IAC W/O CX
Ord Diag: ALTERCATION

CT OF THE ORBITS:

CLINICAL HISTORY PROVIDED: Altercation. Orbital injury.

Multiple sequential sections were obtained through the orbits and there is comminuted nasal bone fracture with deviation of the nasal septum to the right posteriorly with spurring which is chronic in appearance. I do not see a definite orbital fracture. There is mucosal thickening ethmoid air cells bilaterally and frontal sinuses more on right than left. There is also air within the soft tissues over the anterior and lateral right maxillary sinus although no definite orbital floor or sinus fractures are seen. There is soft tissue swelling over the orbits and face bilaterally.

IMPRESSION:

COMMINUTED NASAL BONE FRACTURE. MUCOSAL THICKENING BILATERAL ETHMOID AND FRONTAL SINUSES WHICH IS MORE PROMINENT ON RIGHT THAN THE LEFT, PROBABLY RELATED TO TRAUMA AND MILD BLEEDING. SOFT TISSUE AIR OVER THE RIGHT MAXILLARY SINUS BUT NO DEFINITE ORBITAL OR MAXILLARY FRACTURE IS IDENTIFIED. PROMINENT DEVIATION OF THE NASAL SEPTUM APPEARS CHRONIC.

/Read By/ MILTON R RAINES, M.D.
/Released By/ MILTON R RAINES, M.D.
11/07/05 2016
Typed By: SKY
Typed On: 11/07/05 1650

PRELIMINARY UNLESS RELEASED

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: slh9337
DATE 5/19/2009



INTERDISCIPLINARY PATIENT/FAMILY EDUCATION FLOW SHEET

INITIAL	PROVIDER SIGNATURE	INITIALS	PROVIDER SIGNATURE
	<i>[Signature]</i>		

DOCUMENTATION LEGEND:

Topic				
M - Medications	P - Procedure	D - Diet	A - ADL	FDI - Food/Drug Interaction
E - Equipment	C - Consents	DX - Diagnosis	T - Treatment	Other _____
Readiness to Learn				
Ability to Understand Verbal Instruction:	VP - Poor	VA - Average	VG - Good	
Cognitively Able to Understand:	CP - Poor	CA - Average	CG - Good	
Ability to Understand Written Instruction:	WP - Poor	WA - Average	WG - Good	
Barriers to Learning				
P - Physical	V - Visual	C - Cognitive	M - Motivation	R - Religious
R - Reading	L - Language	CL - Cultural	AR - Age Related	E - Emotional
A - Auditory	N - None			
Who				
PT - Patient	F - Family	O - Other		
Learning Method Used				
D - Demonstration	TV - Video/TV/Audio	W - Written	GR - Group Work	
P - Pamphlet	V - Verbal Instruction	MED - Medication Instruction Sheet	O - Other	
Comprehension				
1. Verbalized or demonstrated understanding.		4. Medical condition limits understanding.		
2. Not receptive/cooperative.		5. _____		
3. Needs further instruction.		6. _____		

DATE/ TIME	PROVIDER INITIAL	TOPIC	READINESS TO LEARN	BARRIERS TO LEARNING	WHO	LEARNING METHOD USED	COMPREHENSION	PREFERRED LEARNING METHOD:
								INFORMATION TAUGHT
11/7/05 1740	<i>[Signature]</i>	MR	VG	N	to	U	1	Needs education on study procedure done with as directed w/ AA JV



Interdisciplinary
Patient/Family
Education Flow Sheet

PATIENT INFORMATION

ERT MCBAY, GARY
11/07/2005
PHYSICIAN, E R
DOB 08/05/1976
M 29Y

ERT BRICE
MR 0000359017
0531100375

